

## Appendix D: Initial Proposed CCO Accountability Metrics (transparency metrics also listed)

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	Transformational Measures	
<p>1. Experience of Care*^ – Key domains TBD from member experience survey (version TBD and may alternate by year) <i>Domain(s): Member experience &amp; activation</i> <i>Data type: Survey (collected by OHA)</i> <i>Also part of: Medicaid Adult Core, CHIPRA, Medicare ACOs, Medicare Part C, OR PCPCH, others</i></p> <p>2. Rate of tobacco use among CCO enrollees*^ <i>Domain(s): Prevention, outpatient physical, overall health status, cost control</i> <i>Data type: Survey</i> <i>Also part of: Nat'l Quality Strategy</i></p> <p>3. Access – Outpatient and ED utilization per member-month*^ <i>Domain(s): Access, community engagement</i> <i>Data type: Claims/encounter</i> <i>Also part of: CHIPRA Core, NCQA HEDIS</i></p> <p>4. BMI assessment &amp; follow-up plan*^ / Weight assessment and counseling for children and adolescents <i>Domain(s): Prevention, outpatient physical</i> <i>Data type: Medical record</i> <i>Also part of: Medicare ACOs, OR PCPCH, CHIPRA</i></p> <p>5. Screening for clinical depression and follow-up plan^ <i>Domain(s): Mental health</i> <i>Data type: medical record</i> <i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p>6. Alcohol misuse - Screening, brief intervention, referral for treatment (SBIRT)^</p>	<p>1. Rate of early childhood caries <i>Domain(s): Oral health</i> <i>Data type: Medical record</i> <i>Also part of: HP 2020</i></p> <p>2. Wrap-around care for children – <b>TBD</b> (% Children who receive a mental health assessment within 30 days of DHS custody or other wraparound initiative measure) <i>Domain(s): Care coordination, mental health</i> <i>Data type: TBD</i> <i>Also part of: TBD</i></p> <p>3. Effective contraceptive use - % reproductive age women who do not desire pregnancy using an effective method <i>Domain(s): Women's health, prevention</i> <i>Data type: Survey</i> <i>Also part of:</i></p> <p>4. Planning for end-of-life care: % members over 65 with a POLST form or advanced care plan or surrogate decision maker documented /on file (or documented that these were declined) <i>Domain(s): End-of-life care, care coordination</i> <i>Data type: Administrative or medical record</i> <i>Also part of: Pending</i></p> <p>5. Health and functional status – (1) % members who report the same or better mental and physical health status than 1 year ago*; (2) % members with Medicaid LTC benefit with improvement or stabilization in functional status <i>Domain(s): overall health outcomes</i> <i>Data type: Survey</i></p>	<p>CMS Adult Core Measures including:</p> <ul style="list-style-type: none"> <li>· Flu shots for adults 50-64</li> <li>· Breast &amp; cervical cancer screening</li> <li>· Chlamydia screening</li> <li>· Elective delivery &amp; antenatal steroids, prenatal and post-partum care</li> <li>· Annual HIV visits</li> <li>· Controlling high BP, comprehensive diabetes care</li> <li>· Antidepressant and antipsychotic medication management or adherence</li> <li>· Annual monitoring and for patients on persistent medications</li> <li>· Transition of care record</li> </ul> <p>CHIPRA Core Measures including:</p> <ul style="list-style-type: none"> <li>· Childhood &amp; adolescent immunizations</li> <li>· Developmental screening</li> <li>· Well child visits</li> <li>· Appropriate treatment for children with pharyngitis and otitis media</li> <li>· Annual HbA1C testing</li> <li>· Utilization of dental, ED care (including ED visits for asthma)</li> <li>· Pediatric CLABSI</li> <li>· Follow up for children prescribed ADHD medications</li> </ul>

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	Transformational Measures	
<p><i>Domain(s): Addictions</i>  <i>Data type: medical record</i>  <i>Also part of: OR PCPCH</i></p> <p>7. Initiation &amp; engagement in of alcohol and drug treatment<sup>^</sup>  <i>Domain(s): Addictions</i>  <i>Data type: Claims/encounter</i>  <i>Also part of: Medicaid Adult Core, HEDIS, Meaningful Use, OR PCPCH</i></p> <p>8. Low birth weight <u>or</u> adequacy of prenatal care  <i>Domain(s): Overall health status, MCH</i>  <i>Data type: Claims/encounter</i>  <i>Also part of: CHIPRA</i></p> <p>9. Primary-care sensitive hospital admissions (PQIs) for chronic conditions like diabetes, asthma, CHF, and COPD*<sup>^</sup>  <i>Domain(s): Outpatient physical, prevention, cost control</i>  <i>Data type: Encounter/hospital discharge</i>  <i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p>10. Healthcare-acquired conditions – TBD  <i>Domain(s): Inpatient care</i>  <i>Data type: Clinical</i>  <i>Also part of: CDC and OR HAI reporting, Medicare value-based purchasing, CHIPRA</i></p> <p>11. Follow-up after hospitalization<sup>^</sup> - % of members with follow-up visit within 7 days after hospitalization for mental illness  <i>Domain(s): Care coordination</i>  <i>Data type: Claims/encounter</i>  <i>Also part of: Adult Medicaid Core</i></p>	<p><i>Also part of: Medicare ACOs, MA star ratings(1), SNP(2)</i></p> <p>6. ED visits – Potentially avoidable or other categorization TBD (*<sup>^</sup>)  <i>Domain(s): Outpatient physical, care coordination, cost control</i>  <i>Data type: Claims/encounter</i>  <i>Also part of: TBD</i></p> <p>7. Access - % of primary care providers who report no difficulty obtaining specialty care (including behavioral health services) for members  <i>Domain(s): Access, coordination and integration</i>  <i>Data type: Survey</i>  <i>Also part of: Unknown</i></p> <p>8. Improvement on disparities in health status or quality of health care identified by CCO in community needs assessment  <i>Domain(s): Equity, cost control, potentially others</i>  <i>Data type: mixed</i>  <i>Also part of: Unknown</i></p> <p>9. Community Orientation - TBD  <i>Domain(s): TBD</i>  <i>Data type: TBD</i>  <i>Also part of: TBD</i></p> <p>10. Timely transmission of transition record - % of patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or health care professional within 24 hours  <i>Domain(s): Care coordination</i>  <i>Data type: Attestation</i></p>	<p>SAMSHA National Outcome Measures including:</p> <ul style="list-style-type: none"> <li>· Improvement in housing (adults)</li> <li>· Improvement in employment (adults)</li> <li>· Improvement in school attendance (youth)</li> <li>· Decrease in criminal justice involvement (youth)</li> </ul> <p>Others TBD, for example:</p> <ul style="list-style-type: none"> <li>· Time from enrollment to first encounter and type of first encounter (urgent or non-urgent, physical, mental, etc.)</li> <li>· Initiation and engagement of mental health treatment</li> </ul>

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	Transformational Measures	
<p>12. Readmission rates: (1) Plan all-cause readmissions*^; (2) readmissions to psychiatric care^  <i>Domain(s): Care coordination, cost control</i>  <i>Data type: Claims/encounter</i>  <i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p>13. High needs care coordination – TBD (e.g. % of members identified as high need assigned to intensive care coordination)  <i>Domain(s): Care coordination</i>  <i>Data type: TBD</i>  <i>Also part of: TBD</i></p> <p>14. Medication management –TBD  <i>Domain(s): Care coordination</i>  <i>Data type: TBD</i>  <i>Also part of: TBD</i></p> <p>15. MLR - % of global budget spent on health care and services  <i>Domain(s): Efficiency, cost control</i>  <i>Data type: Administrative</i>  <i>Also part of: Unknown</i></p>	<p><i>Also part of: Adult Medicaid Core</i></p>	
CCO-LTC System Joint Accountability Measures		
<p>1. Care planning - % of members with Medicaid-funded LTC benefits who have a care plan in place.  <i>Domain(s): Care coordination</i>  <i>Data type: Administrative</i>  <i>Also part of: Pending</i></p>	<p>1. Transitions of care - % of LTC patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the care manager or AAA/APD within 1 business day  <i>Domain(s): Care coordination</i>  <i>Data type: Administrative</i>  <i>Also part of: Unknown</i></p>	

## Appendix G: Shared Accountability for Long Term Care

### **Strategic Framework for Coordination and Alignment between Coordinated Care Organizations and Long Term Care** **[Version presented to the Oregon Health Policy Board, Feb. 14, 2012]**

Oregon's proposed Medicaid transformation was initiated by HB 3650, which was passed by the legislature with broad bi-partisan support in June 2011. HB 3650 is the result of a recognition on the part of Oregon's governor and legislature that fundamental structural transformation in the way we deliver and pay for health care services is essential to not only preparing for the implementation of federal health reform in 2014, but to ultimately achieving the triple aim of better health, better health care and lower health care costs. Oregon's goal is to create a health care system that emphasizes prevention and where physical health care, behavioral health care and oral health care are financially integrated within Coordinated Care Organizations (CCOs) that are community-based and given the flexibility to achieve the greatest possible health within available resources. Each CCO will operate within a global budget where they will be held accountable and rewarded for improved quality and outcomes.

This paper presents the strategies for coordination and alignment between CCOs and the Long Term Care (LTC) system. Medicaid-funded LTC services are legislatively excluded from CCO budgets and will continue to be paid for directly by the Department of Human Services (DHS). Medicare covers limited post-hospital acute care, but Medicaid is the primary payer for LTC services. Approximately 24,000 dually eligible beneficiaries in Oregon (about 40 percent) receive Medicaid-funded LTC services. In order to reduce costs in both systems and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to coordinate care and share accountability, including financial accountability.

#### **Oregon's Policy Goals for Health System Transformation:**

- Transform Oregon's Medicaid delivery system so that it focuses on prevention, integration and coordination of health care across the continuum of care to improve outcomes and to bend the cost curve.
- Promote the triple aim of better health, better health care, and lower costs.
- Establish supportive partnerships with CMS to implement innovative strategies that will result in higher quality, more cost effective health care under Medicaid and Medicare.

#### **Oregon's Department of Human Services Policy Goals for Long Term Care Placement Decisions:**

LTC placement decisions should balance:

- The preferences and goals of the person;
- The right of the person to live as independently as possible, in the least restrictive setting; and
- The cost of the living arrangement.

#### **System Coordination between CCO/LTC:**

System and care coordination are key activities of Health System Transformation and are critical activities for a high performing healthcare system that coordinates services and activities of the Area Agency on Aging (AAA)/State's Aged and People with Disabilities (APD) system and their contractors with the CCOs and their delivery system network. Successful coordination will improve person-centered

care, align care and service delivery and provide the right amount of care at the right time for beneficiaries across the LTC system. CCOs and the AAA/APD system will need to implement care coordination strategies tailored to the unique skills and service environments associated with home care, home and community based care, acute care, skilled nursing facility care and long term nursing care.

The CCO Implementation Proposal to the legislature includes several references to the expectations of the CCOs related to coordination and accountability for LTC:

“Since individuals receiving Medicaid-funded LTC services and supports represent a significant population served by CCOs, CCOs should include these individuals and the LTC delivery system in the community needs assessment processes and policy development structure.” (Pg. 37)

“CCOs should demonstrate the following elements of care coordination in their applications for certification:

- How they will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member’s care, and, in the absence of full health information technology capabilities, how they will implement a standardized approach to patient follow-up.
- How they will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long term care services and crisis management services.
- How they will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of each in the process of communication.
- How they will meet State goals and expectations for coordination of care for individuals receiving Medicaid-funded long term care services given the exclusion of Medicaid-funded long term services from CCO global budgets.” (Pg. 21)

“A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the CCO and/or to the LTC system. Other elements of shared accountability between CCOs and the LTC system will include: contractual elements, such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems through a memorandum of understanding, a contract or other mechanism; and reporting of metrics related to better coordination between the two systems.” (Pg. 37)

### **Contracts/MOUs**

To implement and formalize coordination and ensure relationships exist between CCOs and the local LTC offices, CCOs will be required to work with the local AAA or APD local office to develop a Memorandum of Understanding (MOU) or contract, detailing how they will coordinate and the roles and responsibilities of each side. This MOU or contract will be the mechanism for the two systems to operationalize the requirements for coordination in a way that works for both systems locally. An MOU could be used if the arrangement between the CCO and AAA is limited to an agreement about roles and processes. The CCO and AAA may also decide to have a formal financial arrangement (contract) with upfront CCO investment in local office activities and/or shared savings from the CCO to the local office based on improved health outcomes and reduced medical costs. Core requirements for care coordination between the LTC system and CCOs are represented in Appendix A.

OHA will oversee these contracts/MOUs by reviewing documentation (copies of the contract/MOU), using compliance oversight mechanisms and performance metrics to ensure that required activities are conducted and that individuals receiving Medicaid-funded LTC are jointly served by CCOs and APD/AAAs.

OHA and DHS will ensure that member/client complaints or grievances would follow the “no wrong door” policy and follow the standard complaints and grievance processes set forth by CCOs, AAA/APD, DHS, and DMAP. Thus, a complaint to an AAA/APD local office about a CCO would be properly routed through the CCO complaint process. The Oregon Health Policy Board has determined that individuals will receive plain language information on their member rights including complaints and grievances.

#### **Division of Roles/Responsibility:**

Due to the exclusion of the Medicaid-funded LTSS in HB 3650, clear delineation of roles and responsibilities are needed to reduce duplication, improve efficiency, and meet the goals of Health System Transformation (HST). The key roles and benefits of CCOs and LTC are listed below.

##### CCO:

- Role: Health care delivery including preventive, early intervention and acute health services, behavioral health services, health services coordination and information sharing, care team coordination, use of non-traditional health workers (health system navigators, peer wellness counselors, community health workers), Patient-Centered Primary Care Homes, after hours medical consultation.
- Post Acute Skilled Care and Transitions to Medicaid-funded LTC: (see below)
- Benefits: Medical/primary care; hospital services; mental health/behavioral health; medical transportation; Medicare Skilled Nursing (including Medicaid cost sharing for Medicare Skilled Nursing benefit); Medicare and Medicaid home health; durable medical equipment; emergency transport (ambulance); home enteral/parenteral nutrition and IV services; rehabilitation services such as, physical, occupational, and behavioral/mental health therapies; medical-surgical services; pharmaceutical services including Medicare Part D; speech-language pathology; audiology; and hearing aid services; transplant services; hospice services and other palliative care.

##### LTC:

- AAA/APD Role: Coordination and information sharing with CCO, LTC financial/service eligibility, LTSS authorization and placement (home and community based/Nursing Facility except when Medicare skilled), LTSS case management coordination and troubleshooting, Adult Protective Services, contracting for Medicaid LTC providers, Licensing and Quality Assurance, LTC Ombudsman. Eligibility and enrollment for Medicaid, Medicaid low-income co-pay.
- Post Acute Skilled Care and Transitions to Medicaid-funded LTC: (see below)
- Medicaid-funded LTC Benefits: In-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, LTC nursing facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, Home Delivered Meals, administrative examinations and reports, non-medical transportation (except in some regions where contracted to transportation brokerages), PACE state plan (including Medicare benefits).
- Other AAA/APD Supports and Services: As the Aging and Disability Resource Connection the following are provided: information and assistance, options counseling; care transitions coaching; nursing facility transition/diversion; connection to evidence based chronic disease

self-management, Aging and health promotion; Supplemental Nutrition Assistance Program (SNAP), Older American's Act Services (information/Assistance/Outreach, In-home assistance, Family Caregiver Supports, Oregon Project Independence, respite, transportation, home and congregate meals, legal assistance, caregiver counseling/support, training).

Other Resources and Community Programs to Maintain Independence:

- Low-income housing, Low Income Energy Assistance Program, Department of Veteran's services, Parish Nursing, Food banks, community specific charities and non-profit organizations, volunteers.

Post Acute Skilled Care:

Oregon will explore with CMS the following federal Medicare flexibilities around post acute skilled care:

- Waiving requirements for an inpatient stay before allowing skilled benefit (currently a 3-day stay is required). Instead, individuals who meet skilled criteria from the emergency room or other settings could enter skilled care;
- Allowing skilled care to be provided in non-skilled settings (would need to ensure that individuals retain access to their full Medicare and Medicaid benefits).

**Outstanding Issue: Roles related to Post Acute Skilled Care and Transitions to Medicaid-funded LTC**

Stakeholders responded to initial drafts of this document with divergent perspectives on roles for CCOs and AAA/APD offices during the critical period after an acute care episode as well as transitions to Medicaid-funded LTC. Following is the original draft section shared with stakeholders.

*Post Acute Skilled Care: CCO would have responsibility for payment and coordination for post acute care and placement decisions for up to the first 100 days after an individual leaves an acute care setting while the individual meets Medicare skilled criteria. This includes primary responsibility for placement in the least restrictive service setting (including consideration of Home and Community Based Services or HCBS) while ensuring health outcomes and value and considering the individual's desires and goals. CCOs also have the responsibility for payment and coordination for the home health benefit.*

Transitions to Medicaid-funded LTC:

*CCO would coordinate transitions to Medicaid-funded LTC by notifying AAA/APD within 3 days of post acute placement when post acute care is expected to last 30 days or less. CCOs would notify AAA/APD no later than the 15<sup>th</sup> day of post acute placement if post acute care is expected to last more than 30 days. CCO would also notify AAA/APD within 3 days of post acute placement for any individuals currently served by AAA/APD in Medicaid-funded LTC.*

Key stakeholder perspectives:

- Limited resources require a close examination of areas with potential for duplication of effort, and in order to best manage transitions, CCOs should have primary responsibility for medically related post acute care placements, as the draft language above would allow.
- Ensuring communications and coordination between CCOs and AAA/APD is particularly critical during transitions, and stakeholders were concerned that this proposal would minimize the role of AAA/APD during this time and could lead to inappropriate placements.

**Promising Models and Practices:**

As part of their CCO certification application, entities will describe how they will coordinate care for individuals receiving Medicaid-funded LTC services, and may incorporate the promising models identified through planning work and stakeholder workgroups. Oregon has identified several models currently being tested or practiced to better coordinate care. These include co-location approaches, services in congregate settings, and clinician/home based programs. Co-location models consist of locating LTC staff in medical settings such as a hospital or the health plan locating a staff in the LTC office. Services in congregate settings bring services to natural communities or settings, such as low-income housing or PACE program settings where individuals congregate. Clinician/home-based programs use a variety of clinicians to assess and provide services in an individual's home or living setting.

**Shared Accountability**

In order to ensure that coordination between the two systems is occurring and to align incentives between the two systems to provide quality care and produce the best health and functional outcomes for individuals, there will be a system of shared accountability, including traditional accountability mechanisms, reporting of key metrics, and financial accountability.

*Traditional Mechanisms for Shared Accountability*

As a foundation, shared accountability will be created via the traditional accountability mechanisms the state has with each partner.

- The CCO criteria and contracts with OHA will include specific requirements for CCO coordination with AAA/APD and LTC providers.
- Similarly, DHS will hold LTC providers to requirements (via contracts with DHS, rules or other mechanisms such as provider enrollment agreements) to better coordinate with the medical system, appropriate to the provider type, and these provider agreements, contracts and rules will also be revised to change or remove any requirements that are contrary to the goals of CCO and LTC coordination.
- DHS Inter-governmental Agreements with AAAs and the state APD local office policies will also include requirements to coordinate with the CCO.
- All of these vehicles could also be used to put in place minimum requirements for performance on key metrics.
- OHA/DHS will monitor and enforce compliance for the above mechanisms via contract and rule compliance and oversight processes, work plans, and corrective action plans.

*Metrics/Monitoring*

Metrics for performance reporting will be selected related to high leverage areas where the activities of one system have significant impacts on the costs and outcomes realized in the other system, or where coordination between the two systems is key to reducing costs and improving outcomes. These high leverage areas will be used to identify process and structure measures and related outcome measures. The process and structure measures will be used to ensure that best practice approaches are being put in place to ensure coordination between the two systems, and the outcome measures will be used to assess whether those approaches have been successful.

In addition, there will be an overarching set of outcomes or goals related to the alignment between the two systems. The overarching goals will not only be linked to a subset of metrics, but also linked to



quality assurance, quality improvement and evaluation processes. The overarching outcomes or goals for the two systems include:

- Delivery of Person-Centered Care
- Delivery of Care in Most Appropriate Setting
- Improved Quality of Life
- Reduced Avoidable ER or Inpatient Hospitalizations
- Support Highest Level of Functioning and Independence
- Reduced Total Cost of Care
- Improved or Maintained Health Outcomes

The table below includes examples of high leverage areas, and a subset of potential or illustrative metrics associated with each high leverage area. The relative impact of each system will vary by measure, and therefore, the complete metric framework for shared accountability will specify how measures will apply to CCOs, AAA/APD local offices, and LTC providers – whether all metrics will apply to each entity or some subset of metrics will apply to specific entities.

<b>Shared Accountability High Leverage Area</b>	<b>Sample or Illustrative Process/Structure Measures</b>	<b>Sample or Illustrative Outcome Measures</b>
<b>CCO Person Centered Care process linked with LTC care planning processes</b>	% LTC members that have person centered care plan developed jointly by the member, LTC providers, PCPCH, AAA/APD case manager	Member experience of care overall: Getting needed care & getting care quickly Seamless experience of care across CCO and LTC providers Consumer experience and satisfaction
<b>Care Coordination</b>	% LTC members medical records that integrate elements from, and share elements with, Patient-Centered Primary Care Homes (PCPCH), specialty providers, AAA/APD local offices and other social service providers	% members with improved or maintained functional status in ambulation, ADLs, transfers, bathing, managing medications, pain etc.
<b>Intensive Care Coordination for High Needs Members</b>	% high needs members in LTC assigned to the CCO intensive care coordinator with preferred ratio of high need members	Readmission rates (30 day risk-adjusted for hospital and inpatient psychiatric)
<b>Communication across CCO and LTC systems</b>	% LTC providers for whom a strategy for Interoperability and health information exchange has been established	Provider experience and Satisfaction  Ease of referral and authorizations
<b>Integrated Behavioral Health and Substance Abuse Treatment</b>	% LTC members with positive screening for mental illness or substance use disorder engaged in treatment 30 days from screening date	Rate of emergency department use for individuals with serious mental illness or substance use disorders
<b>Transitions of care for LTC-LTC</b>	% transitions where information transfer occurred same day (e.g.	Rate of emergency department use following transfer

<b>Shared Accountability High Leverage Area</b>	<b>Sample or Illustrative Process/Structure Measures</b>	<b>Sample or Illustrative Outcome Measures</b>
<b>LTC-Acute Acute-Post Acute Acute-LTC Post-Acute - LTC</b>	nurse to nurse consult or receipt of physician's discharge	
<b>End of Life Care Planning or Advanced Care Planning</b>	% relevant subpopulation offered advanced planning or POLST	% members whose end-of-life care matches preferences in POLST registry

The overall approach is to develop a balanced set of metrics, so that utilization metrics are balanced with process metrics and health and functional outcomes, to ensure that the overall measurement approach is person-centered and avoids perverse incentives. The measurement and reporting of these metrics will be phased in, with a general approach of:

- First year: reporting process measures and feasible outcomes measures<sup>16</sup>, while the full set of outcome measures are being developed. The development of final measures is also dependent on negotiation with, and requirements of, CMS related to the CMS Financial Alignment Demonstration for integrating care for individuals dually eligible for Medicare and Medicaid. These requirements and negotiations are expected to be completed by summer 2012.
- Second year or later: measurement and reporting of the full set of outcome measures begin.
- Measurement development and changes to measures for shared accountability for LTC will be defined through the same process used for overall CCO metric development.

The data that is reported will be closely monitored to track the impacts of CCO implementation and detect any unintended consequences in either system, which will be addressed through the traditional accountability mechanisms described above.

#### *Financial Accountability*

A selection of these metrics will also be used as the basis to hold CCOs and the LTC system financially accountable for their impact on and coordination with each other. As with the metrics, the development of final financial alignment requirements is also dependent on negotiation with, and requirements of, CMS related to the CMS Financial Alignment Demonstration. There are several options for holding CCOs financially accountable:

- Making a portion of overall CCO quality incentive payments be related to metrics for shared accountability with LTC. Depending on available funding, OHA plans to offer incentives to reinforce these reporting and performance expectations, with the specific incentive design to be determined. CCOs who did not meet performance expectations related to shared accountability for LTC could be at risk for this payment.
- For LTC providers and AAAs/APD offices, financial incentives tied to performance metrics, depending on availability of funding. The development of these metrics would consider which metrics and incentives are appropriate for AAA/APD offices as well as different types and sizes of providers.
- Shared savings arrangement between CCOs and LTC partners (providers and AAAs/APD offices) around benchmarks such as reduced rehospitalization rates and ED utilization (and/or other

<sup>16</sup> Note: some outcomes measures may not be feasible to collect in the first year for several reasons: outcomes reflect longer term impacts of changes, the measure is not yet clearly defined, the collection mechanism is not defined, etc.

health system costs). CCOs and LTC partners could elect to come to their own shared savings agreements. Absent those agreements, the state could coordinate shared savings arrangements, for example, adjusting a portion of CCO payments for sharing between CCOs and LTC partners if benchmarks were achieved.

- Exploring with CMS the use of other mechanisms, including tying a portion of demonstration quality payments to shared accountability. Under the Financial Alignment Demonstration a portion of participating CCOs' aggregate payment will be withheld until the end of the contract year to be evaluated against established quality standards, which could include standards related to shared accountability with LTC; if the CCO meets the quality standards for the given year they will be able to receive the portion of the payment withheld.

As with the measurement, financial accountability will be phased in, with a focus on process measures in the first year while work is underway to develop outcome and utilization/cost metrics and to find the best way to tie incentives to them. Some consideration will be given if one side of CCO-AAA/APD fails to participate.

#### *Other Accountability Mechanisms*

Other approaches that may be considered for sharing accountability with LTC providers would include potentially giving LTC providers preferred contracting status depending on their performance on metrics or in coordinating with CCOs, and potentially putting in place a public ratings or rankings system to publicize performance on quality measures similar to the CMS nursing home compare system.

[FOR FULL DOCUMENT INCLUDING APPENDIX – SEE THE FOLLOWING LINK:

<http://www.oregon.gov/OHA/OHPB/meetings/2012/2012-0214-cco-strategic-framework.pdf>]